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Dr. Call had devoted time to religious, governmental and civic affairs. He had served in the LDS Church as bishop, stake president, and until his release a month ago, had served as regional representative.

He served a term as Utah State senator from 1966 to 1969, was treasurer of the Utah County Republican Central Committee, a delegate to the National Republican Convention, and a member of the Executive Committee of the Utah County Republican Committee.

Survivors include his wife, June, one son, Dr. Richard Call II, and two daughters.

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WARREN G. EYRE, M.D.
A Professional Corporation
Dermatology
Hospital Medical Center
930 NORTH 500 WEST
PROVO, UTAH 84604

STOCK NO GA-032

FAMILY GROUP RECORD

PLACES: Sharon, Windsor, Vt.

ENTER ALL DATA IN THIS ORDER:
DATES: 14 Apr 1794

To indicate that a child is an ancestor of the person submitting the sheet, place an "X" behind the number pertaining to that child.

HUSBAND

Born _____ Place _____
Chr. _____ Place _____
Marr. _____ Place _____
Died _____ Place _____
Bur. _____ Place _____

HUSBAND'S FATHER _____ HUSBAND'S MOTHER _____

HUSBAND'S OTHER WIVES _____

WIFE

Born _____ Place _____
Chr. _____ Place _____
Died _____ Place _____
Bur. _____ Place _____

WIFE'S FATHER _____ WIFE'S MOTHER _____

WIFE'S OTHER HUSBANDS _____

Husband E Bruce MCIFF
Wife

Ward Examiners: 1. 2.

Stake or Mission

E. Bruce Mcliff, M.D.

SET

TION OF ABOVE TO WIFE

NO ☐

CE DATA

SEX M F	CHILDREN List each child (whether living or dead) in order of birth — Given Names	SURNAME	WHEN BORN DAY	MONTH	YEAR	WHERE BORN TOWN	COUNTY	STATE OR COUNTRY	DATE OF FIRST MARRIAGE / TO WHOM	DAY
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										

SOURCES OF INFORMATION

OTHER MARRIAGES

Friday, March 2, 1984 THE HERALD, Provo, Utah, — Page 15

Timely issues, news, features, including family, food, fashion

Liddle, Bolick Wedding Set

Shauna Lynn Liddle, daughter of Jamey and Virginia Wooten of Pleasant Grove, will marry Daniel Bolick, son of Dr. Larry Bolick and Glenda Bolick of Provo on Friday, March 2, in The Church of Jesus Christ of Latter-day Saints Provo Temple.

A reception will honor the couple that evening from 7-9:30 p.m. at the Edgemont S. Stake Center, 350 E. 2950 N. Friends and relatives are invited to attend.

Matron of honor will be Carrie Maag.

The bride-elect graduated from Timpview High and attends Utah Technical College.

Her fiance graduated from Provo High and from Brigham Young University, where he studied art and design. He served an LDS Mission to Taiwan.

The couple will live in Orem.

Daniel Bolick
Shauna Lynn Liddle

E. BRUCE McIFF, MD

Weddings

Lyon, McIff Marriage Planned

Jill McIff, daughter of Dr. and Mrs. E. Bruce McIff, Provo will marry Grant Lyon, son of Mr. and Mrs. Gary F. Lyon, Mesa Arizona, Thursday, in The Church of Jesus Christ of Latter-day Saints Salt Lake Temple.

A reception will honor the couple that evening, 7-9:30 p.m. at the home of the bride, 3329 N. Piute Drive.

Bridal attendants are Karen Farnsworth, Cathie McIff, Pam Lyon and Lisi Lyon with Cindy McIff as flower girl.

Best man is Blake Parrish with Rick Lyon, Greg McIff and Steve McIff.

The bride-elect graduated from Timpview High where she was a memeber of the forensics team. She participated in a sememster abroad in Vienna, Austria, and is majoring in Nursing at Brigham Young University.

Her fiance graduated from Mountain View High, Mesa, Arizona where he wa junior class president, student body president and Seminary Council president. He served an LDS Mission to Cali, Colombia and is majoring in accounting at BYU.

The couple will live in Provo.

Jill McIff
Grant Lyon

MEDICINE IN THE MID 1980's

E. Bruce Mciff, M.D.

Health care systems in every Western country are in severe financial difficulty. It makes little difference whether the country's health care is totally nationalized as in Great Britain or partially nationalized as in the United States or as not nationalized at all such as in France. This fact does not allow for great optimism as we approach the mid 1980's. There are in place inevitable forces that will change the American health care delivery system. We have witnessed dramatic changes in the past year. They represent the tip of the iceberg. I have serious doubts as to whether we can alter significantly the end result, that being some form of contract delivery of medical care services.

Does this then mean that all our efforts are in vain and that we ought to succumb to the forces that appear to be shaping our future? After giving that considerable thought, the answer is a resounding no. Even if we were to draw a conclusion as to exactly what form of contract medicine we will be delivering if our efforts are successful in holding it off for three to five years, it will have a significant impact on practicing physicians. I further believe we can help construct the system that we are going to spend most of the rest of our medical lives in. We cannot do it individually. We cannot do it as a reactionary force. We can do it collectively and it is to that end that the body of the Utah State Medical Association must aggressively assert itself locally and nationally. Never in modern medicine's history has there been a greater need for physicians to look beyond the scope of their own practices and extend their services and commit some of their resources to organized medicine than there is today.

E. Bruce Mciff, M.D., a radiologist from Provo, Utah and present USMA Council Chairman for Health Services, is also President-elect of the Utah State Medical Association.

FACTORS INFLUENCING THE CHANGING HEALTH DELIVERY SYSTEM.

While it would be impossible to enumerate all of the factors currently affecting the changing medical care system, there are some that would seem to be more forceful than others. To look to the past and our choice of bedfellows would only be an effort in futility. Never before has the desire for well-being been more predominant or the collective tab for health care larger. We can anticipate with inflation hovering in the eight percent range that we will spend $500 billion on health care in the year 1990 and a full $1 trillion on medical expenses by the end of the century. The plight of the elderly will continue to grow. It is impressive to recognize that more people over the age of 65 are alive today than all those who ever lived past 65 years since the beginning of recorded history.

With medicine being on the verge of making "the blind see, the lame walk, the deaf hear", it is unthinkable to allow us to be forced into an era of denying care or even delaying services for several years such as the nationalized systems do. I strongly believe that every American regardless of age should be able to seek the best and ultimate in medical care services. As one retires he would be able to look forward to an improving and increasing quality of life and would not be denied the significant and dramatic advances made by medical science.

A PHYSICIANS'S PARADOX

In some cases yesterday's solutions have brought us today's problems. In 1965 the nation listed 87 accredited medical schools. By 1982 that number had jumped to 126. The plan to educate more physicians has backfired. The Physician surplus situation is used to the advantage of the regulators. By 1990, out of an estimated 600,000 practicing physicians 100,000 will represent an over-supply. The term physician surplus is a kind term. We are truly facing a physician glut. With the prospect of DRG's forcing the closing of some hospital doors, tens of thousands of physicians will find themselves homeless and forced to accept whatever the controlled competition models, i.e., corporate medicine, wants to hand out.

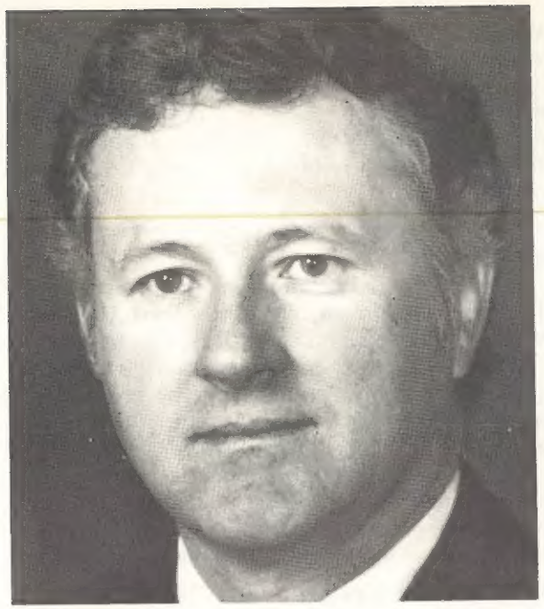
LITIGATION

Probably the most insidious and most difficult factor to deal with will be the continuing medical liability crisis. It is this factor alone that has the potential to bring medical care and the health delivery system as we know it to its knees. It is not difficult to project in the very near future a scenario that concludes by removing the constant threat of litigation as a trade for acquiescing to the contract model of medical care delivery no matter who may be that contracting agent.

OPTIONS FOR THE USMA

Each individual practitioner and the USMA must continue to seek to provide viable options for handling health costs and health care demands. Mr. Peter Drucker in a recent editorial in the New York Times made one of the clearest most succinct statements that I have read. He suggests that the most viable option is to use the market mechanism as a regulator to the fullest extent possible, to have the individual family pay its own health care costs up to a certain percentage of pretax income and then as President Eisenhower proposed thirty years ago have the government provide a catastrophic insurance policy that would pay all health care costs above that amount without any upper limit. He suggests that we avoid the triage system, i.e., the denial of access to health care that the controlled competition models would like to force us into, and that above all the rules and regulation systems of the past and of present are doo
could well offer some const
lines that may indeed have r

E. BRUCE McIff, M.D.



E. Bruce McIff, M.D., a radiologist from Provo, Utah and present USMA Council Chairman for Health Services was nominated as a candidate for President-elect.

MEDICINE IN THE MID-1980's

E. Bruce McIff, M.D.

Medical practice as we have known it in the past is rapidly coming to an end. While we cannot be certain which direction changes in medicine will take, communication, cooperation, and mutual support of physicians appear to be vital in making sure our profession plays a part in the changes.

I believe that it is imperative to maintain strong communications with the hospitals, medical societies and specialty societies. If we choose as individuals or as societies to protect our own interests, we can be assured that we will see an end to private practice as we have known it. If we remain strongly unified and rededicate ourselves to Hypocratic principles rather than attempt to be entrepreneurs, I believe we can maintain and enhance our role of physicians dedicated to the care and treatment of the sick, elderly, and injured.

We must continue to be the decisionmakers in the delivery of health care. We must continue to seek quality and excellence, defending and protecting patients' rights. We must work together to see that our system is not destroyed by a quick fix, quick cure, quick diagnosis, approach to dealing with health cost problems. We cannot allow practictioners, whose credentials do not include thorough training, to take over the care of patients.

If we maintain a strong organization and continue to strengthen our levels of expertise and our individual practices, we can remain in a good position to share in the decisionmaking concerning medical practice today. We will need leadership dedicated to actively working for physicians. We cannot passively leave our fate for others to decide.

E. Bruce McIff

ANTHONY W. MIDDLETON, M.D.
ANTHONY W. MIDDLETON, JR., M.D.
GEORGE W. MIDDLETON, M.D.

MIDDLETON UROLOGICAL ASSOCIATES
A PROFESSIONAL CORPORATION
110 MEDICAL TOWERS
1060 EAST FIRST SOUTH
SALT LAKE CITY, UTAH 84102
PHONE 531-9435

October 26, 1984

R. Raymond Green, M.D.
45 South Main St.
Heber City, UT 84032

Re: William Hull, Jr.

Dear Dr. Green:

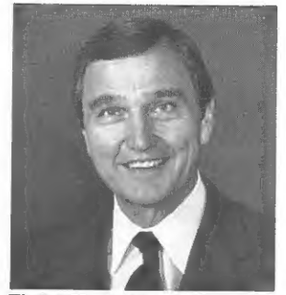
I regret to inform you that Mr. Hull was readmitted to Cottonwood Hospital because of a bladder neck contracture resulting from his previous TUR's.

This was resected and I anticipate discharge from the hospital tomorrow. Meanwhile, I would like to thank you again for the opportunity to share in his management.

Sincerely,

George W. Middleton, M.D.

GWM:Meditech/9



Thales H. Smith, M.D.

THALES H. SMITH, M.D.

USMA BULLETIN

Utah State Medical Association

Volume No. 32
Issue No. 6

June 1984

540 East 5th South
Salt Lake City, Utah 84102
Telephone (801) 355-7477

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Editorial

"Cliff Dancers?"

by Gary M. Watts, M.D.

Profound changes in the traditional delivery of health care in this country are under way and are creating considerable consternation among physicians. Politicians and public policy people are tampering with doctor-patient relationships with protentous possibilities. Prospective reimbursement schemes that put physicians at risk create 'tough' ethical dilemmas for many in the profession. How do we cope? How much do we give up? What basic principles are inviolable? Whittaker Chambers posed similar questions in 1957 when he wrote about the future of the conservative movement in the United States: "Those who remian in the world, if they will not surrender on its terms, must maneuver within its terms. That is what conservatives must decide: how much to give in order to survive at all; how much to give in order not to give up basic principles. And of course that results in a dance along a precipice. Many will drop over, and, always, the cliff dancers will hear the screaming curses of those who fall, or be numbed by the sullen silence of those, nobler sould perhaps, who will not join the dance." Is participation in an HMO or IPA a form of cliff dancing: Can we fall off the precipice and not be aware of it?

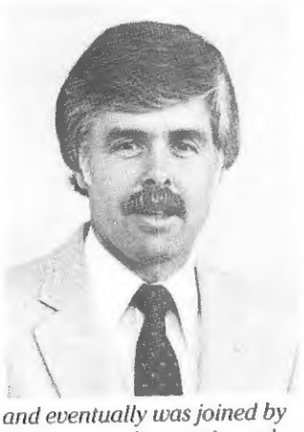
Arnold Relman in a review of Paul Starr's book, entitled *The Social Transformation of American Medicine*, suggests two reasons why physicians have enjoyed special treatment by society during the past fifty years: (1) Their moral commitment to put patients' welfare above personal gain, and (2) technical competence. I think Relman is correct, and I am now convinced we are on the verge of losing our special status and prestige because of the direction economic incentives are taking us. One cannot help but see a subtle, gradual erosion of our commitment to put the patient's welfare first. Economics will dictate less utilization of diagnostic tests and occasional missed diagnoses will result. "Screaming curses" initially will later be rationalized as inevitable because of the system. Technical competence:

(Continued on page 7)

Gary M Watts MD

Opinion The Gate is Closing

by Gary Watts, M.D.



A man built a home adjacent to a wood occupied by wild pigs. At first, the pigs were wary of the farmer and avoided any contact. The farmer noted their activity and determined to capture them. He began by putting several ears of corn out for them to eat. The pigs ignored the offering initially, but eventually one of the pigs slipped out of the woods, and grabbed an ear of corn. Emboldened by his easy success, the pig returned for more corn and eventually was joined by other pigs. Still wary, they would dart from the woods, grab the corn and return to their natural habitat to enjoy their easily obtained meal. Gradually they became more trusting and began to languish at the feeding trough. Some pigs actually began to stay and eat at the trough until they were completely satisfied before returning to the woods. Over time, they became fat and lazy and began to lose their ability to forage for themselves because of the ease of obtaining corn from the wily farmer. Of course, the inevitable happened. The farmer built a fence around the trough and closed the gate while the unsuspecting pigs were indulging themselves at the trough.

The medical profession has been indulging itself at the government trough, a fence has been built and the gate is now closing. That initial ear of corn has grown into several bushels and we are dependent upon it. Under the "feeding" program, expenses in Part B (physicians' and outpatient services) of Medicare have risen eightfold since 1967. One sixth of our income, on average, is now derived from Medicare and some specialists receive over one-third of their income from that source. But, Medicare can no longer afford to feed us. A 32% reduction in total Medicare disbursements, a 48% increase in revenues, or some combination of the two must be achieved to bring the Hospital Insurance Trust Fund (Medicare Part A) into actuarial balance over the next 25 years. The Supplemental Medical Insurance Trust Fund (Part B Medicare) has become the fastest growing major domestic program and since it derives most of its revenues from the general fund, it is having a significant adverse impact on the increasing federal deficit.

We find ourselves in an uncomfortable setting. We have grown dependent upon Medicare but Medicare is reluctant to or unable to pay our bills. In fact, Medicare is saying we better accept what they will pay or they will find someone else to provide the service. Many of us are too dependent upon Medicare to refuse patients and with the marked anticipated increase in the number of practicing physicians over the next ten years, it seems likely that Medicare will find a sufficient number of physicians willing to accept their proposals.

What should be done? We should deal with Medicare as we deal with any patients who are unable to pay their bills. We should first examine our bill and be sure it is fair. We should then examine their ability to pay and their sincerity and discount the bill appropriate to their needs. The public believes our fees are too high and has expressed strong sentiment that Medicare should limit payments to doctors and not allow additional charges to be passed on to beneficiaries. I tend to agree with the public. Our bills are generally too high and can be moderated. Why not have each specialty society meet with representatives of Medicare and arrive at a suggested, fair uniform fee schedule for each specialty and practice location and eliminate the hocus-pocus of 'reasonable' and prevailing charges? As fees are moderated to help Medicare, we should insist on faster and more efficient claims processing. Who among us would not discount a fee for a 30 day turn-around instead of the 75-90 days we are now experiencing?

In addition to a reduction of our fee schedules, Medicare has three other options which need our support. These include:

1. Increasing the users' tax on consumption of alcohol and tobacco as a means of increasing revenues. The relationship between use of these products and increasing health care costs is sufficient justification for a tax increase. Federal excise taxes on alcohol have not been increased for 30 years. A doubling of that tax, plus a 50% increase in the cigarette excise tax would yield at least $100 billion in additional revenues by 1995.
2. Increasing the age of eligibility for Medicare. It has been estimated that a phased increase in the age of eligibility from 65 to 67 would reduce expenditures over $80 billion through 1995.
3. Decreasing utilization and thus reducing expenditures by creation of an HMO type delivery system.

We should be supportive of these three options as they will raise revenues, decrease expenditures and result in decreased pressure upon physicians to lower or freeze fees.

In the long run, a conciliatory, cooperative approach will pay far greater returns than an adversarial, uncooperative attitude. The potential is there to restore some of the respect that has been lost for our profession over the past two to three decades. People could once again say we do care about something other than the almighty dollar and wouldn't that be nice?! Let's take the lead and help solve the fiscal problems of Medicare. It is basically a good program and deserves our support.

Dental Consultants